Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2013	2013_109153_0023	T-143-13, T455-13	Complaint

Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7

Long-Term Care Home/Foyer de soins de longue durée

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 28, September 3, 5, 6, 9, 10, 11, 2013.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Associate Director of Care(ADOC), Physician, Care Co-ordinator, Registered Nurse(RN), Scheduling Co-ordinator, Personal Support Workers(PSW), Residents and Substitute Decision Maker(SDM).

During the course of the inspection, the inspector(s) reviewed clinical health records, staff schedules and home policies related to replacement of staff, infection control, medication review and administration.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that actions were taken to meet the needs of the resident with responsive behaviors including reassessment and interventions.
A review of the progress notes indicated Resident #2 exhibited inappropriate behavior numerous times on the evening shift.
The behavior consisted of verbal/ physical aggression, throwing a walker at other residents/staff, slamming doors, ringing call bells and threatening individuals in the area.
Resident #2 was prescribed medication at bedtime when required for behaviors.
A review of the electronic medication record indicated the prescribed medication was not administered when the resident demonstrated inappropriate behaviors. .
Registered staff failed to reassess the resident when there was a significant increase of behaviors on the evening shift and implement action to respond to the behaviors.
When interviewed the Director of Care confirmed the resident should have been reassessed and appropriate intervention be implemented. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure actions are taken to meet the needs of the resident with responsive behaviors including reassessment and intervention, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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1. The licensee did not ensure drugs are administered to the resident in accordance with the directions for use specified by the prescriber.
The physician prescribed pain medication three times a day for discomfort.
According to the electronic medication administration record, Resident #2 did not receive the prescribed dose three times a day because the resident was sleeping.
Resident #2 did not receive the third dose of the prescribed medication on the following dates:
March 1, 2, 6,13,14, 20. 21, 27, 29 and 30, 2013.
A review of the clinical health record indicated a significant increase in the behavior exhibited by Resident #2 in March 2013 in comparison to the incidents demonstrated in February 2013.
When interviewed the Director of Care confirmed the resident should have received the pain medication as prescribed. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure there was a documented reassessment of each resident's drug regime on a quarterly basis for Resident #2.
A documented reassessment of Resident #2's drug regime was completed on April 13, 2012 for the period from April 13, 2012 to July 12, 2012.
The next documented reassessment was completed on August 6, 2012 for the period covering August 6 to November 4, 2012.This reassessment was completed 24 days after the previous reassessment was scheduled to be completed.
An additional reassessment of Resident #2's drug regime was completed on December 7, 2012.
This reassessment was completed 32 days after the previous reassessment was scheduled to be completed.
A documented reassessment of Resident #2's drug regime was not completed on a quarterly basis.
When interviewed the Director of Care confirmed the reassessment of Resident #2's drug regime should have been completed on a quarterly basis. [s. 134. (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a documented reassessment of each resident's drug regime on a quarterly basis, to be implemented voluntarily.

Issued on this 9th day of October, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Lynn Parsons